Revista Brasileira de Enfermagem
REBEn

ORIGINAL ARTICLE

Vulnerability in the health of young transgender women living with HIV/AIDS

Vulnerabilidade em saúde das jovens transexuais que vivem com HIV/aids

Vulnerabilidad en salud de las jóvenes transexuales que viven con VIH/SIDA

Rafaela Greice da Silva[I]
ORCID: 0000-0002-3782-1545

Paula Daniella de Abreu[II]
ORCID: 0000-0001-8756-8173

Ednaldo Cavalcante de Araújo[I]
ORCID: 0000-0002-1834-4544

Alef Diogo da Silva Santana[I]
ORCID: 0000-0001-8165-6412

Josueida de Carvalho Sousa[I]
ORCID: 0000-0001-5547-5298

Jorge Lyra[I]
ORCID: 0000-0002-5381-2059

Claudia Benedita dos Santos[II]
ORCID: 0000-0001-7241-7508

[I]*Universidade Federal de Pernambuco. Recife, Pernambuco, Brazil.*
[II]*Universidade de São Paulo. Ribeirão Preto, São Paulo, Brazil.*

How to cite this article:
Silva RG, Abreu PD, Araújo EC, Santana ADS, Sousa JC, Lyra J, et al. Vulnerability in the health of young transgender women living with HIV/AIDS. Rev Bras Enferm. 2020;73(5):e20190046. doi: http://dx.doi.org/10.1590/0034-7167-2019-0046

Corresponding author:
Paula Daniella de Abreu
E-mail: pauladdabreu@gmail.com

EDITOR IN CHIEF: Antonio José de Almeida Filho
ASSOCIATE EDITOR: Alexandre Balsanelli

Submission: 01-24-2019 **Approval:** 03-23-2020

ABSTRACT

Objectives: to analyze the health vulnerability of young female transgender living with HIV/AIDS. **Methods:** qualitative, descriptive, and exploratory study, based on the theoretical reference of Social Representation and concept of vulnerability; developed with six transgender women in a reference Hospital for HIV/AIDS. We analyzed the individual interviews, recorded, and transcribed in full, in the IRaMuTeQ software by Similitude Analysis. **Results:** the thematic categories are listed based on the Ayres reference: 1) Individual dimension of vulnerability to HIV/AIDS; 2) Social dimension of vulnerability to HIV/AIDS; 3) Programmatic dimension of the vulnerability. **Final Considerations:** the young female transsexual living with HIV/AIDS experience a context of vulnerability in health associated with a lack of knowledge and difficulties for the realization of self-care. The study evidenced the representations of social abjection and unpreparedness of the health team that compose the Primary Attention in Health in promoting qualified assistance for the execution of the effective and humanized care.
Descriptors: Nursing; HIV Infections; Acquired Immunodeficiency Syndrome; Health Vulnerability; Transgender Persons.

RESUMO

Objetivos: analisar a vulnerabilidade em saúde das jovens transexuais femininas que vivem com HIV/aids. **Métodos:** estudo qualitativo, descritivo e exploratório, fundamentado no referencial teórico de Representação Social e conceito de vulnerabilidade; desenvolvido com seis mulheres transexuais em um hospital de referência para HIV/aids. Analisaram-se as entrevistas individuais, gravadas e transcritas na íntegra, no *software* IRaMuTeQ, pela Análise de Similitude. **Resultados:** elencaram-se as categorias temáticas a partir do referencial de Ayres: 1) Processos relacionais que operam na vulnerabilidade individual ao HIV/aids; 2) Produção e reprodução da dimensão social da vulnerabilidade ao HIV/Aids; 3) Condições dadas de precarização do cuidado e o impacto da vulnerabilidade programática. **Considerações Finais:** as jovens transexuais femininas que vivem com HIV/aids vivenciam contexto de vulnerabilidade em saúde associado a falta de conhecimento e dificuldades para a efetivação do autocuidado. Evidenciaram-se representações de abjeção social e despreparo da equipe da saúde que compõe a Atenção Primária em Saúde em promover assistência qualificada para a execução do cuidado efetivo e humanizado.
Descritores: Enfermagem; Infecções por HIV; Síndrome da Imunodeficiência Adquirida; Vulnerabilidade em Saúde; Pessoas Transgênero.

RESUMEN

Objetivos: analizar la vulnerabilidad en salud de las jóvenes transexuales femeninas que viven con VIH/sida. Métodos: estudio cualitativo, descriptivo y exploratorio, fundamentado en el referencial teórico de Representación Social y concepto de vulnerabilidad; desarrollado con seis mujeres transexuales en un hospital de referencia para VIH/SIDA. Se ha analizado las entrevistas individuales, grabadas y transcritas en su totalidad, en el software IRaMuTeQ por el Análisis de Similitud. **Resultados:** se ha seleccionadas las categorías temáticas a partir del referencial de Ayres: 1) Procesos relacionales que operan en la vulnerabilidad individual al VIH/sida; 2) Producción y reproducción de la dimensión social de la vulnerabilidad al VIH/sida; 3) Condiciones dadas de precarización del cuidado y el impacto de la vulnerabilidad programática. **Conclusiones:** las jóvenes transexuales femeninas que viven con VIH/SIDA experimentan un contexto de vulnerabilidad en salud relacionado a la falta de conocimiento y dificultades para la efectuación del autocuidado. Ha sido evidenciadas representaciones de abyección social y falta de preparación del equipo de salud que compone la Atención Primaria en Salud en promover asistencia calificada para la ejecución del cuidado efectivo y humanizado.
Descriptores: Enfermería; Infecciones por VIH; Síndrome de Inmunodeficiencia Adquirida; Vulnerabilidad en Salud; Personas Transgénero.

CC BY

INTRODUCTION

The need to perceive young transgender women as citizens who present their rights violated is evident since this awareness contributes to coping with the vulnerabilities pre-established in society. Given this situation, humanistic actions are recommended for the empowerment and protagonism of these people through overcoming stigma and jointly (re) building their social support networks and their life projects[1].

Gender identity is referred to as the gender which people identify with and expresses themselves, which may differ (transgender) or not (cisgender) from the gender that was assigned to them at birth, defined by biological sex. This concept does not predict sexual orientation since it consists of experiencing the individual's sexuality (lesbian sexual orientation, heterosexual sexual orientation, gay male sexual orientation, bisexual sexual orientation, pansexual sexual orientation, or asexual). Among transgender people, there are transvestites and transgender women, who, respectively, build a female gender expression and recognition as a transgender woman[1-3].

There is a context of vulnerability of trans women resulting from transmisogyny (discrimination by family, school, in health services, and prison, based on arbitrariness, harassment, and lack of support, which contribute to the search for income through prostitution). Brazil is in first place in the ranking of murders to transvestites and transgenders: of the 331 cases of murders registered between October 2018 and September 2019, the majority occurred in Brazil (130), followed by Mexico (63) and the United States of America (30). From January 2008 to September 2019, the total number of cases reported in 74 countries was 3,314[4].

Also considered is the degree of vulnerability associated with xenophobia (migration is associated with *bullying*, violence, and criminalization), racism, sexism, misogyny, and hate crimes, especially for transgender women who are sex workers. In the USA, the majority of transgender people murdered are black and Native American transgender women (90%). In France, Italy, Portugal, and Spain, 65% of registered murder victims were transgender migrant women from Africa and Central and South America[4].

Transphobic violence is perceived in the context of individual, social, community, and structural vulnerability. Extreme violence and denial of rights regarding the civic participation of transgender people (in particular, transvestites and transgender women) results in the acquisition of income through sex work[5-6]. We highlight that sex work provides opportunities for socialization, friendship, expression of glamor, femininity, and acceptance, which are configured in support networks for the expression of gender identity and coping with transphobia, but which also exposes them to risks[1,7].

With the epidemic boom of the acquired immunodeficiency syndrome (aids), it was possible to identify the probabilistic associations of HIV with population groups as a strategy for disease prevention. However, the idea of a "risk group" was not enough to explain the onset of HIV and only contributed to the "sanitary isolation" and "social death" of stigmatized groups[8].

"Risk behavior" started to be considered as a preponderant factor for infection based on the individual's sexual practices, but this concept refers to "individual blame" and does not consider, for example, empowerment and the impoverishment process of the disease. Then, the concept of vulnerability emerged, in order to broaden the understanding of susceptibility, which deals with individual factors (degree of knowledge, information, possibilities, and interests for applying preventive actions), social (political, economic and social context) and programmatic (social and health institutions) in the social determination of the health-disease process[8]. We reiterate the confrontation of HIV/AIDS as a factor of vulnerability in the National Policy of Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites and Transgenders (LGBT) since prejudice contributes to the clandestine activity of sexuality and unfavorable situations to the safety and prevention of diseases[9-11].

In this context, nurses are not prepared in their training to care for transgender people[12]. We emphasize, however, the ethical commitment and role of nursing in recognizing and managing health education actions that consider the context of vulnerability of young transgender women living with HIV. Given this setting, the guiding question was followed: What is the context of vulnerability of young female transgenders living with HIV/AIDS?

OBJECTIVES

To analyze the vulnerability in the health of young female transgenders living with HIV/AIDS.

METHODS

Ethical aspects

The Research Ethics Committee of the *Centro de Ciências da Saúde da* UFPE (CCS/UFPE - Health Sciences Center of the Federal University of Pernambuco) approved this research, which followed the standards established by Resolution 466 of December 12, 2012, of the National Health Council of the Ministry of Health, which provides for the guidelines and standards that regulate research involving human beings. The anonymity of the participants was guaranteed; as requested, the term "Butterfly" replaced the social names, for being a symbol of transgender women that represents the process of metamorphosis, freedom, and overcoming.

Type of study

Qualitative, descriptive, exploratory study[13], based on the theoretical and methodological references of the Theory of Social Representations, proposed by Sergi Moscovici[14], and on the concept of vulnerability developed by Ayres[15]. The first reference deals with knowledge constructed by common sense based on the processes of anchoring and objectification[14]. The second reference deals with the understanding of the dimensions of vulnerability from the individual, social, and programmatic aspects[15].

Methodological procedures

Study scenario

The study was carried out in the outpatient clinic of a reference hospital for people with HIV/AIDS, located in the city of Recife, Pernambuco (PE), Brazil. We chose this place to meet the criterion of intentionality, since this hospital is responsible for 60%

of the demands in the state of Pernambuco, besides providing multiprofessional health follow-up to, on average, 3,000 people per month, mainly young individuals and adults[16]. Thus, this scenario gathered characteristics necessary for the development of research by integrating the population of interest.

Data source

The study consists of young transgender women, who composed the sample through the criterion of saturation of the responses selected by progressive inclusion. We observed the deepening of the statements and reach of the scope and diversity for the detailed understanding of the object of study, to support the questions listed without worrying about generalization[17].

We interviewed six young transgender women. The definition of "young" considered was of the World Health Organization (WHO) and Ministry of Health[18], namely, a period that extends from 15 to 24 years of age. However, to minimize possible biases, young people over 18 years old were included. The stigmas related to the theme may have limited the number of participants. However, the effective conduct of interviews enabled the quality of the results obtained to achieve the saturation of responses.

Participants were chosen by convenience sampling based on the following inclusion criteria: being transgender, identifying as being of the female gender, not having undergone gender reassignment surgery; to be heterosexual, being HIV-positive, or undergoing treatment for AIDS; and having casual partners. The approach with the participants occurred through the multidisciplinary team. People with hearing impairment were excluded since the researcher did not have a mastery of the Brazilian Sign Language.

Data collection and organization

Data were collected from April to June 2017. Initially, contact was made with the institution to obtain consent on the use of the location. We previously clarified the health team about the purpose of the research, the proposed objective, and procedures for data collection. The invitation to join the research took place in the waiting room of the hospital. Once accepted, the participants proceeded to a room reserved by the institution to conduct the individual interview.

The script of the semi-structured interview was composed of three guiding topics: 1) Tell about your life story *(childhood, family, friends, partners, work colleagues, milestones, school, work, health services)*; 2) Tell what it means for you to live with HIV/AIDS; 3) How do you perceive social relationships in the daily lives of young transgenders living with HIV/AIDS? The interviews, recorded on a digital device, lasted an average of one hour and 10 minutes. They were transcribed and subsequently submitted to analysis.

It is noteworthy that the meeting provided verbal communication to obtain success in information, with deepening in order to provide representations (acting, thinking, and feeling) under the influences of social dynamics in groups that experience a context of vulnerability[13]. The study allowed to enter the construction of knowledge and perceptions, aiming to know, to a full extent, the person in the midst of her life history and social interaction in the elaboration of representations and conceptions of meaning[19-20].

Data analysis

The corpus of analysis was processed using the lexical analysis technique, with the aid of the Software Interface de R *pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRaMuTeQ). The textual analysis of the data was obtained using the Similarity Analysis method, which is based on the theory of graphs and allows the identification of co-occurrences among the most meaningful words in the structure that presents connectivity between the terms; thus, a textual corpus was obtained, guided by the hierarchy between the words and their surroundings[21].

Validity and reliability/Rigor

Regular meetings with members of the research group ensured the methodological rigor. It comprised undergraduate, graduate students, and researchers, who develop studies in the area of health education, vulnerabilities, sexual orientation and gender identities in nursing care scenarios. We discussed data collection techniques, methods of sampling, production, analysis, and interpretation of data. The interviews were transcribed on the same day after data collection to avoid possible loss of corpus information from the corpus. The processing and analysis of the data were made possible in consonance with the critical realism methodology and constructivist epistemology that supported this study. The conduct and reporting of this study followed the Consolidated Criteria for Reporting Qualitative Studies[2223].

RESULTS

Six transgender women living with HIV/AIDS participated in the study, who were, on average, 21.6 years old. The average time of being diagnosed was between 14 to 19 years old, and the monthly family income reported was less than one minimum wage to three minimum wages (MW/2017 = R$ 937.00). Regarding the level of education, two had incomplete elementary education, one elementary education, two complete secondary education, and one higher education. Of the six women, four worked in the informal labor market as sex workers; one, in the position of hairdresser; and the other, in pedagogical support.

We carried out the discussion of the predefined thematic categories, in the light of the concept of vulnerability proposed by Ayres, after the interpretation of the connectivity between the most frequent terms established by the corpus similarity analysis: *prejudice, family, problem, depression, childhood, prostitution, woman, transgender, gay, school, HIV, sex, prevention, treatment, condom, respect, illness, examination, health, medicine, nurse, doctor, social name, consultation, Community health clinic, work, hospital*.

Individual dimension of vulnerability to HIV/AIDS

Participants reported individual experiences of self-care, knowledge, and sexual practices: "To prevent is to use condoms, only that" (Butterfly 1). The study highlighted the interests and limits for daily preventive practice, the use of condoms, and the meanings associated with disease prevention: "[...] HIV prevention for me means that I am protecting myself from other diseases. I protect myself in anal sex, not in oral [...]" (Butterfly 2).

The context of sex work and limits for negotiating condoms with clients stood out: "My clients don't know that I have HIV, some ask me not to use a condom" (Butterfly 1). They reported the impact produced by the news of HIV seropositivity associated with the degree of information about their infection:

> [...] *when I got this news that I had HIV/AIDS, everything for me is the same, because people say that HIV is the virus, AIDS is the bacterium, the disease, for me it is all the same, you have no cure for any, from the moment you get the virus, you are stuck with it for the rest of your life* [...] (Butterfly 6)

The study revealed the psycho-emotional and concrete situations related to rejection and situations of intrafamily violence: "My aunt raised me until I was fourteen, I was beaten up by my aunt to clean the house, I was beaten up a lot [...]" (Butterfly 5); "[...] My mother always had a psychological problem, my older sister was the one who raised me, and I was raped by her husband [...]" (Butterfly 2). The reports highlighted family relationships since childhood and difficulties related to the transgender youth:

> *The story of my life is so sad; my childhood was good only until my mother was alive until I was 9 years old. When my mother died, everything went down* [...] *I got to know this LGBT world, I started dressing as a woman, my family didn't want to give me money to buy clothes.* (Butterfly 4)

> *At 16, I already knew that I didn't want to be a man anymore, I didn't want to be gay anymore, I wanted to dress up as a woman, I wanted to be a transgender; it was very difficult, there were many comings and goings, I left home at 16* [...] (Butterfly 6)

Social dimension of vulnerability to HIV/AIDS

The influence of gender identity was associated with the lack of social, political, structural and moral support, with the provision of income through sex work: " My work is difficult, turning tricks, there is a lot of discrimination [...] I work turning tricks, I have sex, oral, anal, passive and active [...]" (Butterfly 6); "I'm an escort girl, I stay on the street corner, I wait for the client, and they usually ask how much it is, and I say it depends on what they want to do, each thing has a price [...] "(Butterfly 5). The streets and night work appear as a possible space for gender identity expression, feeling of socialization, and inclusion in the labor market, even if it is informal:

> [...] *My clients don't know that I have HIV, some ask me not to use a condom, but I didn't give in, I don't like it. Once or so, I did it, and I truly regret it, out of emotion, when it's kind of like this, you know? There was no time, and that was it. In the group, there is a lot of joking around, disturbance; everyone says that has it, no one knows who has it and who does not, it is always an argument* [...] (Butterfly 1)

> [...] *I started dressing like a woman, my family didn't want to give me money to buy clothes, then I started working in prostitution, I got HIV with 14 years old* [...] (Butterfly 4)

> [...] *about 6 years ago, 7 years ago, it was harder, and I just found prostitution and what I did... When I became a transvestite, I got straight to prostitution, I've worked in prostitution, I've lived in prostitution, and I used to just thought about it because it's money that comes easy, then we're happy because every month you make almost four grant, every week* [...] (Butterfly 6)

The study evidenced that most participants interrupted vocational and higher education and the racial relations that attenuate the context of social vulnerability. The transformation of bodies and the legitimization of gender identity differs from the cisnormativity present in society, which hinders the access of transgender people to the formal labor market:

> *I became a boy, then I started working, I worked in three companies, without prejudice, normal, but dressing as a boy, then I let my hair grow* [...] *as you can see, my hair is long, then I went looking for a job, but even if I am not dressing like a woman, because my hair is long, I can not find a job* [...] (Butterfly 6)

> [...] *I'm afraid of not standing it (formal employment) and want to go back (to sex work) because there is the issue of humiliation. I talked to a girl the other day, who worked at a steakhouse, and she was hired again now. She had left because the manager who was the owner's brother was treating her as "him," he full of prejudice against her, all the time, and the owner loved her, everyone loved her, she had already worked there and only left because of him. I wouldn't stand these things* [...] (Butterfly 5)

> *I could not get a job, I'm suffering prejudice to get a job today because of my hair, as it is long, and because I took a lot of hormones my body is still kind of female, I have hips* [...] (Butterfly 6)

Programmatic dimension of the vulnerability

We verified the programmatic dimension of vulnerability with emphasis on health care since the limitations of these services regarding human, material, ethical, and care resources stood out:

> *The healthcare never has a doctor, never has a nurse, they have to go to the UPA, almost dying to be assisted or send to seek the hospital* [...] (Butterfly 2)

> *Health services are complicated, in the SUS, here in the outpatient clinic, the care is good, but not in the community health center, here to get an appointment also takes a long time* [...] *They don't meet my needs* [...] (Butterfly 3)

> [...] *I don't go at the community health center, because if I feel something, I rather come to the hospital because it has everything here, it is better than going to the health center, I no longer go to the health center* [...] (Butterfly 6)

The study referred to the inclusion in high complexity care, the hospital, preferences during care, and the obtainment of drugs for the treatment of HIV/AIDS. The participants reported discriminatory situations, permeated by the disrespect for guaranteeing the rights of recognition of the social name. It was possible to perceive institutional weaknesses in health care:

> [...] *I argued with the nurse inside the hospital because I went to take medicine* [...] *she asked my name, I said the social name, then when she comes back to get the paper, she calls me by the*

legal name, then I corrected her saying my social name, then she said no, the injection was for another name, then I said "look at the bottom," then she apologized to me... I was all dressed up, makeup on, lipstick, hair, with women's clothes, then she gave me the medicine [...] (Butterfly 5)

Here at the outpatient clinic, I am embraced, thank God. Professionals treat me right here, only when the paper has my legal name and beside the social name [...] *only they should put the social name on top, who will read the bottom and then read the beginning?* [...] *One day when they called me by the legal name, I sat as if nothing had happened, and kept calling, even with the social name next to it marked in yellow* [...] (Butterfly 5)

DISCUSSION

In the social context, the AIDS epidemic associated with sexual practices considered "deviant" of certain social groups, especially LGBT people. It is known, however, that AIDS was not only found among specific groups but became popular, affecting men and women, cisgender and transgender, and people with different sexual orientation, under different facets of vulnerability and susceptibility to HIV. We highlight the stigma that relates HIV/AIDS to transgender women, which culminates in social rejection and representations of "abjection" to people considered outside the cis heteronormative standards[24].

The understanding of the vulnerabilities to the singularities linked to factors of exposure to HIV/AIDS became evident[25]. Given this, individual, social, and programmatic dimensions emerged in the light of historical and social aspects, in order to elucidate the multiple factors associated with being affected by the epidemic[8]. The study referred to the individual dimension of vulnerability through the degree of knowledge, availability of information, and attitudes given the difficulties that may interfere with protective conduct[15].

As for the meanings of HIV/AIDS for transgender women, they demonstrated and reinforced the lack of qualified information about the risks to which they are exposed. The verbalization refers to the social stigma related both to gender identity, which culminates in social exclusion, and to the condition present in the daily lives of transgender women living with HIV, even in health institutions.

Another similar study highlighted the demand for policies aimed at health education to reduce the vulnerabilities of transgender women in the Caribbean and Latin America. It associated the limited knowledge of transgender women about HIV with lower rates of condom use. More than two-thirds of transgender women believed that a person could contract HIV through mosquito bites (70.61%), 73.08% reported that HIV could be transmitted through food sharing, 55.13% believed that there were several ways to transmit/contract HIV, 44.87% believed that HIV was transmitted only through anal sex, 79.49% knew that HIV could be transmitted through oral sex, and 79.49% believed that those with HIV would soon die[26].

With regard to the support network, the participants reposted fragile family relationships and precarious bonds regarding schooling and employability. The interviews emphasized that the expression of transgender identity culminates in the denial of social rights, difficulty in inclusion in the formal labor market and institutional prejudices, limiting factors for well-being, and quality of life. Most of the participants mentioned the search for sex work as the main source of income for survival because of the scarce job opportunities offered.

We observed the context of family conflicts due to the expression of female transgender gender identity in the youth period, which contributes to the fragility of support bonds and culminates in social exclusion. A study found a greater degree of vulnerability to marginalization due to the lack of emotional, structural, and financial support from their support network[27].

It is known that the lack of emotional support, trans-specific health services, and information sharing are aspects that make the social context of transgender women permeated by vulnerabilities that relate not only to the biomedical aspect but also to a social and political perspective. We must focus on a research practice open to new "interpretative models" of the health-disease-care complex, capable of articulating research methods, strategies, and techniques, by rescuing the socio-political historicity related to human rights[28].

We understand the social dimension of the impact of the socio-political and economic aspect impact on the supply of resources that influence the determination of the health-disease process[15]. In a study about transgender sex workers, it was possible to observe that inconsistent condom use, infrequent HIV and sexually transmitted infections (STI) screening and high drug use during sex work were higher compared to cisgender sex workers. Transgender female sex workers had higher rates of HIV (12.4%) and syphilis (28.3%) than cisgender women - 11.1% and 23.7%, respectively. The emerging need for intervention is emphasized because of uncontrolled individual morbidity and the high potential for transmission to clients and other sexual partners[29].

The research evidenced the exposure to STIs due to the sex workers not using condoms in sexual relations, based on decontextualized forms of prevention and bargaining by clients to perform sexual fetishes, associated with the precarious quality of information and the need for survival. Aspects such as low self-esteem, fear, anxiety, stigma, difficulty in accessing basic services (education, health) are directly related to the quality of life of transgender women living with HIV/AIDS, especially when analyzing the aspects of adherence to medication and monitoring in health services[30].

The participants reported practicing with clients oral, anal, receptive, and active sex permeated by discrimination and subordination to their requirements. This evidence corroborated a study carried out in China with 220 transgender sex workers, which evidenced a high prevalence of HIV due to unsafe sexual practices. It referred to the high prevalence of anal sex without a condom with male sexual partners, not clients[31].

Another prospective study conducted with 199 transgender women from New York, observed the race/skin color relationship to HIV infection. Statistically, black and Hispanic transgender women were more involved in sex work and more exposed to unprotected receptive anal sex, with greater susceptibility to STIs[32].

Participants reported representations of abjection[24] that provide exposure to psychological, verbal, physical, and sexual

violence, in addition to precarious individual experiences of self-care, sexual knowledge, and practices, based on the incipience of knowledge about HIV/AIDS prevention. The research highlighted the exclusionary social context as a reason for sex work to acquire income. However, the possibilities for safe sexual practices have become limited.

A study carried out in Canada with transgender women sex workers found experiences of violence provoked by clients due to transmisogyny. Transphobic violence characterizes the experiences of sex work as having a higher risk compared to cisgender sex workers. Sometimes, the body of transgender women represents a "commercial product" for the sexual satisfaction of cisgender men[33].

The programmatic dimension consists of the resolutive capacity of health services to minimize problems through the implementation of policies and actions by sectors/social actors[15]. This study evidenced the programmatic dimension of Primary Health Care and the weaknesses in the provision of care directed to the specificities of transgender women living with HIV/AIDS.

Participants in this and another study carried out in the Dominican Republic verbalized the limitations for inclusion in community-based health services. A similar study highlighted that 73.08% of transgender sex workers reported difficulties in obtaining medical care[26].

Therefore, public health efforts to detect and treat infections are essential based on implementing harm reduction policy and health education about condom use in all sexual relations, in addition to providing greater access to Pre-Exposure Prophylaxis (PrEP) for HIV prevention[29]. We reiterated the immediate need for other studies that deal with community-based health strategies and social justice practices to face risks and deaths (physical and symbolic), invisibility, and stigma to transgender women[24].

Study Limitations

We believe that the theme addressed is inserted in a social context permeated by prejudices and stigmas, which may have limited the number of participants, the transgender women's verbalization, and collaboration with the research.

Contributions to nursing, health, or public policy fields

This study will underpin health education in order to provide the articulation of necessary information for health practices considered safe, horizontally. In this sense, it will consider aspects already present in the context of young transgender women, and, based on this knowledge, it will take the opportunity of reflection of these people from their own experience so that they can adopt safe sexual approaches and promote the prevention of STIs.

FINAL CONSIDERATIONS

Young female transgenders living with HIV/AIDS experience a context of vulnerability in health associated with insufficient knowledge and difficulties in carrying out self-care. This study showed the unpreparedness of the health team that composes Primary Health Care to promote qualified care that considers lifestyle, social conditions, and permanent education for the execution of effective and humanized care.

We observed that society's prejudice against transgender women is intensified because they take on prostitution as a professional job and because they are living with HIV, all of which involve stigma, social taboos, and exclusion.

We suggested problematizing the vulnerability in transgender women's health. Given the many stigmas related to seropositivity since the first reports of the disease in society and the fight for protagonism of the LGBT community, there is a need to discuss such aspects need so that it is possible to orient, debate and (re) formulate new perspectives with a view to comprehensive care.

FUNDING

Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES), *Projeto* PROCAD (CAPES n °: 23.038.000.984.2014-19).

REFERENCES

1. Silva RGLB, Bezerra WC, Queiroz SB. Os impactos das identidades transgênero na sociabilidade de travestis e mulheres transexuais. Rev Ter Ocup Univ São Paulo. 2015;26(3):364-72. doi: 10.11606/issn.2238-6149.v26i3p364-372
2. Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. Lancet [Internet]. 2016[cited 2018 Dec 12];388(10042):390-400. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00683-8/fulltext
3. Abreu PD, Araújo EC, Vasconcelos EMR, Moura JWS, Sousa JC, Santos CB. Transexual "womanhood" and the emergence of transfeminism: rhetorics of HIV/Aids in the light of the queer theory. Texto Contexto Enferm. 2019;28:e20180294. doi: 10.1590/1980-265X-TCE-2018-0294
4. Trans Murder Monitoring (TMM). TMM Update Trans Day of Remembrance 2019. TvT [Internet]. 2019[cited 2020 Jan 5]. Available from: https://transrespect.org/en/tmm-update-trans-day-of-remembrance-2019/
5. Boglarka F, Lukas B. O círculo vicioso da violência: pessoas trans e gênero-diversas, migração e trabalho sexual. TvT [Internet]. 2017[cited 2018 Dec 12];(19):24. Available from: https://transrespect.org/wp-content/uploads/2018/01/TvT-PS-Vol19-2017.pdf
6. Smith LR, Yore J, Triplett DP, Urada L, Nemoto T, Raj A. Impact of Sexual Violence Across the Lifespan on HIV Risk Behaviors Among Transgender Women and Cisgender People Living With HIV. JAIDS J Acquir Immun Def Syndrom [Internet]. 2017[cited 2018 Dec 12];75(4):408-16. Available from: https://journals.lww.com/jaids/Fulltext/2017/08010/Impact_of_Sexual_Violence_Across_the_Lifespan_on.5.aspx

7. Organização Mundial de Saúde. Policy brief: transgender people and HIV [Internet]. 2015[cited 2018 Dec 12]; 34. Available from: https://www.who.int/hiv/pub/transgender/transgender-hiv-policy/en/

8. Ayres JRCM, Calazans GJ, Saletti Filho HC, Franca Jr I. Risco, vulnerabilidade e práticas de prevenção e promoção da saúde. Tratado de saúde coletiva. São Paulo: HUCITEC/ FIOCRUZ [Internet]. 2009[cited 2018 Dec 12];14. Available from: https://edisciplinas.usp.br/pluginfile.php/347426/mod_resource/content/1/risco_vulnearabilidade%20Ayres%20e%20cols.pdf

9. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais. [Internet]. 2013[cited 2018 Oct 22]; 36. Brasília, DF: Ministério da Saúde. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_lesbicas_gays.pdf

10. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Transexualidade e travestilidade na saúde. [Internet]. 2015[cited 2018 Oct 22];100. Brasília, DF: Ministério da Saúde. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/transexualidade_travestilidade_saude.pdf

11. Smith FD. The perioperative care of the transgender patient. AORN J. 2016;103(2):151-163. doi: 10.1213/ANE.0000000000003371

12. Wichinski KA. Providing culturally proficient care for transgender patients. Nurs. 2015;45(2):58-63. doi; 10.1097/01.NURSE.0000456370.79660.f8

13. Minayo MCS (Org.) Pesquisa Social: Teoria, método e criatividade. Petrópolis (RJ): Vozes; 2015.

14. Moscovici S. Representações sociais: investigações em psicologia social. Petrópolis (RJ): Vozes; 2015.

15. Ayres JRCM. Prevenção de Agravos, Promoção da Saúde e Redução da Vulnerabilidade. In: Martins MA, Carrilho FJ, Alves VA, Castilho CG, Wen CL (Orgs). Clínica Médica. Barueri: Manole, 2016.

16. Secretaria Estadual de Saúde (PE). Recife, PE: Secretaria Estadual de Saúde [Internet]. 2019[cited 2019 Jan 10] Available from: http://portal.saude.pe.gov.br/unidades-de-saude-e-servicos/secretaria-executiva-de-atencao-saude/hospital-correia-picanco

17. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Rev Pesqui Qualit [Internet]. 2017[cited 2018 Dec 05];5(7):01-12. Available from: https://edisciplinas.usp.br/pluginfile.php/4111455/mod_resource/content/1/Minayosaturacao.pdf

18. Ministério da Saúde (BR). Secretaria de Atenção à Saúde, Departamento de Ações Programáticas e Estratégicas. Proteger e cuidar da saúde de adolescentes na atenção básica. Brasília (DF): Ministério da Saúde [Internet]. 2017[cited 2018 Oct 22];235. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/proteger_cuidar_adolescentes_atencao_basica.pdf

19. Bauer MW,Gaskell G. Pesquisa qualitativa com texto, imagem, e som: um manual prático. Petrópolis (RJ): Vozes; 2015.

20. Yin RK. Pesquisa qualitativa: do início ao fim. Porto Alegre (RS): Penso; 2016.

21. Camargo BV, Justo AM. IRAMUTEQ: Um software gratuito para análise de dados textuais. Temas Psicol [Internet]. 2013[cited 2018 Dec 05];21(2):513-8. Available from: http://pepsic.bvsalud.org/pdf/tp/v21n2/v21n2a16.pdf

22. Maxwell JA, Miller B. Real and virtual relationship in qualitative data analysis. In: Maxwell JA. A realist approach for qualitative research. Los Angeles: SAGE Publications; 2012.

23. Booth A, Hannes K, Harden A, Noyes J, Harris J. COREQ (Consolidated Criteria for Reporting Qualitative Studies). In: Moher D, Altman D, Schulz K, Simera I, Wager E, editors. Guidelines for reporting health research: a user's manual. Oxford: John Wiley & Sons; 2014.

24. Butler J. Problemas de gênero: feminismo e subversão da identidade. Estudos Femin [Internet]. 2005[cited 2018 Dec 13];13(1):179. Available from: https://periodicos.ufsc.br/index.php/ref/article/viewFile/8534/7828

25. UNAIDS, Who. Global AIDS Monitoring 2018. Geneva: UNAIDS [Internet]. 2017[cited 2018 Dec 13]. Available from: http://www.unaids.org/sites/default/files/media_asset/2017-Global-AIDS-Monitoring_en.pdf

26. Budhwani H, Hearld KR, Hasbun J, Charow R, Rosario S, Tillotson L, et al. Transgender female sex workers' HIV knowledge, experienced stigma, and condom use in the Dominican Republic. PloS One. 2017;12(11):e0186457. doi: 10.1371/journal.pone.0186457

27. Abreu PD, Araújo EC, Vasconcelos EMR, Ramos VP, Moura JWS, Santos ZC, et al. Dynamics of the social network of young female transsexuals that live and deal with HIV/AIDS. Rev Bras Enferm. 2018;72(5):1251-7. doi: 10.1590/0034-7167-2018-0289

28. Dourado I, Silva LAVD, Magno L, Lopes M., Cerqueira C, Prates A., et al. Building bridges: interdisciplinarity in practice. PopTrans Study: a study with transvestites and transsexual women in Salvador, Bahia State, Brazil. Cad Saude Publica. 2016;32(9):e00180415. doi: 10.1590/0102-311x00181415

29. Wickersham JA, Gibson BA, Bazazi AR, Pillai V, Pedersen CJ, Meyer JP, et al. Prevalence of human immunodeficiency virus and sexually transmitted infections among cisgender and transgender women sex workers in greater Kuala Lumpur, Malaysia: Results from a respondent-driven sampling study. Sexually Transmit Dis. 2017;44(11):663-70. doi: 10.1097/OLQ.0000000000000662

30. Oliveira FBMO, Queiroz AAFLN, Sousa, AFL, Moura MEB, Reis RK.Orientação sexual e qualidade de vida de pessoas vivendo com HIV/aids. Rev Bras Enferm. 2017;70(5). doi: 10.1590/0034-7167-2016-0420

31. Cai Y, Wang Z, Lau JT, Li J, Ma T, Liu Y. Prevalence and associated factors of condomless receptive anal intercourse with male clients among transgender women sex workers in Shenyang, China. J Int AIDS Soc [Internet]. 2016[cited 2018 Dec 12];(19):20800. Available from: https://onlinelibrary.wiley.com/doi/full/10.7448/IAS.19.3.20800

32. Nuttbrock LA, Hwahng SJ. Ethnicity, sex work, and incident HIV/STI among transgender women in New York City: a three year prospective study. AIDS Behav [Internet]. 2017[cited 2018 Dec 12]; 21(12):3328-3335. Available from: https://link.springer.com/article/10.1007/s10461-016-1509-4

33. Lyons T, Krüsi A, Pierre L, Kerr T, Small W, Shannon K. Negotiating violence in the context of transphobia and criminalization: The experiences of trans sex workers in Vancouver, Canada. Qualit Health Res [Internet]. 2017[cited 2018 Dec 12]; 27(2):182-90. Available from: https://journals.sagepub.com/doi/abs/10.1177/1049732315613311